CALHOUN COUNTY
Public Health Department
"Working to enhance our community's total well-being"

Flu Vaccine Form

First Name | Middle Initial | Last Name

Address

City | State | Zip Code

Phone Number ___ - ___ - ____ | Age ___ YEARS | Date of Birth MM / DD / YYYY

Male ☐ Female ☐ | Previous Name

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Multi-Race ☐ Other Race ☐ Unknown

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Arab

1. Do you feel sick today?	☐ Yes	☐ No
2. Have you tested positive for COVID-19 in the last 10 days?	☐ Yes	☐ No
3. Have you ever had an allergic reaction to any injectable medication or vaccine? This includes rash, problems breathing, swelling, use of epinephrine or a hospital visit.	☐ Yes	☐ No
4. Do you have a weakened immune system due to HIV/AIDS, cancer, or any other condition or are you taking immunosuppressive treatments like steroids or anti-cancer drugs?	☐ Yes	☐ No
5. Do you have a history of Guillain-Barré Syndrome (GBS)?	☐ Yes	☐ No

For Intranasal Flu Vaccination Only:

1. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	☐ Yes	☐ No
2. Have you had wheezing or asthma in the past 12 months?	☐ Yes	☐ No
3. Do you have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, or metabolic disease (e.g., diabetes)?	☐ Yes	☐ No
4. Do you have a) an open channel between the cerebrospinal fluid (CSF) and the mouth, throat, nose or ear or any other cranial CSF leak, or b) a cochlear implant?	☐ Yes	☐ No
5. Are you currently taking influenza antiviral medications, or have you taken any within the past 3 weeks?	☐ Yes	☐ No
6. Is the person to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin or salicylate-containing medicine?	☐ Yes	☐ No
7. Are you currently pregnant or could become pregnant within the next month?	☐ Yes	☐ No
8. Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐ Yes	☐ No
9. Have you received any vaccines in the last 28 days?	☐ Yes	☐ No

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Calhoun County Public Health Department Consent for Services 2022/2023 Flu

By signing this Consent for Service(s) Form you:

*are giving your permission for you or your dependents to receive services from the Calhoun County Public Health Department (CCPHD).

*have been offered information sheet(s) regarding the service(s) provided, the benefits, possible side effects, risks, and your responsibilities as a client in receiving this service(s) (where applicable).

*have been offered a copy of CCPHD Notice of Privacy Practices.

*permit CCPHD staff to disclose your information among other CCPHD programs in accordance with applicable laws and regulations that may include sensitive health information, such as HIV infection, to provide you with the best treatment.

*authorize insurance benefits to be paid directly to CCPHD, authorize the release of pertinent medical information to insurance carrier(s) to the extent permitted by law and agree to pay non-covered services.

*authorize all immunization information to be submitted to the Michigan Immunization Registry where you will be able to obtain immunization status through a medical provider. (Upon receipt of a written request from an individual who is 20 years of age or older, the department shall make any immunization information in the registry pertaining to that individual inaccessible).

All of your information remains confidential, and a Client Release of Information must be filled out for each release of information requested for agencies outside of CCPHD except for those uses and activities listed in the notice of privacy practice.

Signature _____ Date _____

Legal Guardian _____ Date _____

☐ Vaccine Fact Sheet for Recipients & Caregivers given to vaccine recipient(s).

_____ Staff person completing registration/consent
Initials

FOR CLINIC USE ONLY	
Insurance Information: PRIVATE VFC MEDICAID MEDICARE	
Clinic Location:	Date:
Site of Injection: **RA RL LA LL NASAL**	Dose**: 0.5mL 0.7mL 0.2mL (NAS)**
Immunizer (int.): _____	Brand: Flublok Fluzone Fluzone-HD FluMist
☐ Entered in MCIR _____ Staff Initials	**Lot #:**
Insured Card Holder Information	
Name:	Date of Birth:
Relationship to Patient:	Employer:
Insurance Company Name*:	Insurance ID #:

*For Commercial Insurance: *Must Have Copy of Insurance Card*